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THE USE OF SUPPORTIVE PERSONNEL IN REHABILITATION COUNSELING: PROCESS AND OUTCOME.

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The following issues are discussed in relation to counseling and vocational rehabilitation: (1) the process and outcome of counseling and therapeutic practic, (2) selection of effective counselors, (3) effective counselor training, (4) the role of untrained supportive personnel in the role of counselor aids; and (6) guidelines for the most effective use of supportive personnel in rehabilitation counseling. (PS)

(ARR&TC #259)

The Use of Supportive Personnel in Rehabilitation Counseling: Process and Outcome[1]

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The Use of Supportive Personnel in Rehabilitation Counseling:

Process and Outcome

The many individual disciplines as well as the total field of rehabilitation are currently undergoing rapid expansion in an effort to meet the urgent needs of the physically and emotionally handicapped person. The rehabilitation manpower shortage in all areas is well known. When the projected output of existing professional training programs is matched with projected rehabilitation manpower needs, it is clear that the shortage of professional personnel, particularly in rehabilitation counseling, will continue for some years.

The rapid growth of counseling but the more rapid growth of the need for counseling and therapeutic endeavors has occurred in the midst of a genuine ferment in therapeutic theory, research, and practice. It has become increasingly clear not only from the hard research findings but also from practical experience that effective interpersonal skills lie at the very heart of counseling practice aimed at changing people for the better; effective interpersonal skills indeed lie at the heart of efforts to change people in the broad fields of rehabilitation, mental health, public health, welfare, and indeed the massive area of education. Since effective interpersonal skills are tied more to personal development than professional training in the eyes of many, the use of support personnel has been suggested and tried in therapeutic endeavors both in counseling and in psychotherapy. That support personnel without benefit of professional training can contribute significantly to positive client changes has been suggested by several research studies and by reports of practitioners and by administrators. We at the Arkansas Rehabilitation Research and Training Center are in the process of completing a long-term study of the effectiveness of support personnel in the role of counselor aide. Before detailing the findings to date, it would be worthwhile to review current existing evidence dealing with the training and practice of effective therapeutic interpersonal skills in both professional and nonprofessional personnel working as counselors or psychotherapists.

While the focus of these studies has been primarily on the counseling or therapeutic relationship, other studies suggest that the findings and implications extend far beyond counseling into the broader disciplines involved in the total field of rehabilitation -- both in field office and rehabilitation center facilities.

We in the field of rehabilitation are beginning to recognize that even with the best medical and restorative facilities that the successful vocational rehabilitation of a client rests heavily on our ability to motivate him and to change his behavior. We are beginning to realize that even in brief encounters with a client we, as counselors or rehabilitation workers, have a capacity to hinder or help the client's adjustment and motivation to overcome his physical or emotional handicap. Even when jobs are plentiful our own interpersonal relationship with the client can be a powerful force in motivating him towards gainful employment and positive self concepts, or toward dependency, unproductivity, and fearful withdrawal from the competitive world of work.

In considering the use of supportive personnel in rehabilitation counseling -- its process and its outcome -- I would like to consider six basic questions:

1) What do we currently know about the process and outcome of counseling and therapeutic practice?

2) What kinds of people must be selected to produce effective counselors?

3) What kinds of trainings lead to effective counseling?

4) What kinds of possible roles may relatively untrained supportive personnel play in rehabilitation counseling?

5) What effects on clients do untrained and minimally trained supportive personnel have when functioning in the role of counselor or therapist?

and

6) What guidelines may rationally be drawn from the evidence for the most effective use of supportive personnel in rehabilitation counseling?

Finally, I would like to consider the implications of the evidence dealing with rehabilitation counseling for the broader range of disciplines involved in the total field of vocational rehabilitation. From our learnings in rehabilitation counseling, what can be productively applied to nursing, education, occupational therapy, physical medicine, social work, evaluation, placement, workshop settings and the many and varied professional areas involved in the vocational rehabilitation process.

Ingredients in the Counseling Process That Lead to Client Positive Change

Rehabilitation counseling involves primarily special application of the general principles and techniques underlying the broader fields of counseling and psychotherapy.

The most clear-cut and striking body of evidence available concerning basic ingredients in effective counseling have to do with central interpersonal skills possessed by counselors. As the evidence has accumulated, it has become clear that the counselor's interpersonal skill in relating to clients has much to do with inducing client positive change. While specialized techniques and expert knowledge are believed to be of importance, it is already clear that they are secondary: the effective counselor is first and foremost an expert in interpersonal relations.

I would like to focus now upon some central interpersonal skills that have been shown both by clinical practice and, more importantly, by controlled scientific investigations, to change behavior for better or for worse in a wide variety of people being seen in a wide variety of professional and semiprofessional contacts for a wide variety of purposes. Carefully controlled research in settings attempting to produce significant behavioral change in juvenile delinquents, hospitalized schizophrenics, general in-patient psychotics, a variety of out-patient neurotics, college underachievers, normal classroom school children, both physically and emotionally disabled vocational rehabilitation clients, normal schoolroom children, emotionally upset normal college students, normal parent-child relationships, disturbed parent-child relationships, dormitory counselor-normal student relationships, and normal friendship relationships. In each of these areas research findings to date have strongly indicated that when a person receives from another the interpersonal qualities of accurate empathic understanding, nonpossessive warmth, and genuineness in the relationship, then, positive behavioral and personality changes occur: whereas, when a person receives low or nonexistent levels of accurate empathic understanding, nonpossessive warmth, and genuineness from a significant other, then negative or deteriorative behavioral and personality change ensues.

What is most striking in the research findings to date is that these same interpersonal qualities are motivating, therapeutic, or change inducing whether we measure delinquency behavior in delinquents, psychotic behavior in psychotics, arithmetic and reading achievement in the normal classroom, the degree of intimacy and self-disclosure in normal friendship relationships and parent-child relationships, socialization in preschool children, neurotic behavior in neurotics, vocational progress in the physically, emotionally or mentally handicapped, or indeed the person's sense of adequacy, satisfaction in living, or ability to constructively live across the broad areas so far studied of human relationships and human problems.

Thus, while the bulk of the research developed and grew out of the rather narrow confines of group and individual psychotherapy and counseling, it became clear that accurate empathy, nonpossessive warmth, and genuineness existed along a continuant in all human relationships and, depending upon the degree of their presence, these interpersonal skills or qualities led to the facilitation or inducement of a wide variety of socially valued and individually valued positive behavioral changes, or, an equally wide range of negatively individually and socially appraised behavior changes.

At the present time there already exist over a hundred separate controlled research studies showing that empathy, warmth, and genuineness, depending upon its relative presence or absence, lead to positive or negative behavioral change. The mass of these studies are reviewed in a book (published by Aldine Publishing Company of Chicago, entitled "Toward Effective Counseling and Psychotherapy: Training and Practice"). While the major focus is upon counseling and psychotherapy, the research reviewed and the training programs based on this research delineated in detail are, as Jerome Frank has noted, as applicable to nonprofessional as professional personnel who are involved in the business of behavior change.

That these relationship qualities of accurate empathy, nonpossessive wamth, and genuineness play a central if not totally prepotent role in inducing behavior change is indicated by reference to just a smattering of research studies: in the pioneering work of Whitehorn and Betz at Johns Hopkins Hospital (Betz, 1963 a, 1963b; Whitehorn, 1964; Whitehorn and Betz, 1954) they found that (using somewhat different definitions) psychiatrists showing high levels of these conditions had a seventy-five percent improvement rate in their in-patients while psychiatrists low in these skills had only a twenty-seven percent improvement rate in their in-patients: in a controlled long term study of hospitalized schizophrenics Truax (1963) indicated that all of the patients seen by psychotherapists offering relatively low levels of these interpersonal skills showed either no change or deterioration while seventy percent of the patients seen by therapists offering high levels of empathy, warmth, and genuineness showed varying degrees of improvement; another study at Johns Hopkins (Truax, Wargo, Frank, Imber, Battle, HoehnSaric, Nash and Stone, 1966) indicated that with out-patients psychiatrists providing high levels of these qualities obtained improvement in ninety percent of their patients while those psychiatrists who offered relatively low levels of these interpersonal qualities produced only a fifty percent improvement rate; among juvenile delinquents (Truax and Wargo, 1966a) counselors providing high levels of empathy, warmth, and genuineness produced improvement on eighteen of nineteen separate measures of improvement whereas those providing low conditions produced absolute deterioration on seventeen of the measures and nonsignificant improvement on the other two. Additionally, the delinquents received high levels of empathy, warmth and genuineness, spent almost twice as much time out of an institution during a one-year follow-up. Similarly,

(Truax, Wargo and Cakhuff, 1966) counselors seeing out-patient neurotics and providing high levels of these therapeutic qualities produced above average improvement on twenty-one of twenty-three individual measures of therapeutic outcome, while counselors providing low levels of these same interpersonal skills produced below average improvement on twenty-one of the measures. A study of one hundred and sixty hospitalized patients, (Truax and Wargo, 1966b) patients receiving high levels of empathy, warmth, and genuineness averaged almost twice as many days out of the hospital during a one year follow-up and showed above average improvement on twenty-one of twenty-eight specific measures while patients receiving low levels showed below average improvement on twenty-one measures and only half as many days out of the hospital during a one year follow-up. A study of college underachievers (Dickenson and Truax, 1966) indicated that high levels of empathy, warmth and genuineness induced improved college grades in ninety-four percent of the underachievers while lower levels of empathy, warmth, and genuineness and the control population showed improvement in only fifty percent of the underachievers. In a study of reading achievement in fourth graders (Aspy, 1965) the effects of the teacher's level of empathy, warmth, and genuineness in the normal classroom were every bit as important a determinant of reading achievement as was the pupil's I.Q. In a further study (Aspy and Hadlock, 1966). students taught by teachers high in accurate empathy, warmth, and genuineness showed an absolute reading achievement gain of over twice that obtained for pupils taught by teachers showing lower levels of empathy, warmth and genuineness -- and the truancy rate in classes with low conditions was twice that occurring in high conditions classrooms. Moreover, recent studies (Truax, Tunnell and Glenn, 1966a and 1966b) had indicated that these interpersonal skills are, if anything, more important in persons who are least likely to show positive behavioral change (the most nonverbal and most disturbed clients).

The very consistency and magnitude of the research findings to date raise a host of serious practical and ethical questions about society's professional and nonprofessional attempts to induce or facilitate positive behavioral and personality change in a wide variety of groups and subgroups of human beings. In the research studies conducted to date, it would appear that about one-third of professional or nonprofessional persons have positive interpersonal impact on others, one-third no impact or mixed impact, and one-third negative or deteriorative impact on others. Thus, Strupp (1960) in studying psychiatrists psychologists, and social workers found that less than one-third of the therapists could be rated overall as having positive or warm attitudes towards their clients or patients and that, even worse, somewhat less than five percent of individual responses to sound films of patients in interview situations could be classified as communicating any degree of warmth or acceptance. Moreover, a study of post-internship clinical psychology trainees (Bergin and Solomon, 1963) and a study of post-practicum counseling trainees (Melloh, 1964) indicated that the level of interpersonal skills of these highly trained persons approximated that of undergraduate college students (Baldwin and Lee, 1965).

The solid research evidence suggesting that the counseling process itself can be harmful if wrongly used as well as helpful, and the further evidence suggesting that while large numbers of counselors are indeed highly effective in helping clients, that there are also sizable numbers of counselors who are ineffective and even damaging to clients, tends to explain the puzzling mass of evidence (Truax and Carkhuff, 1967) suggesting that the therapeutic endeavor is, on the average, ineffective. Thus it appears that the demonstrable positive effects of competent counselors is offset by a sizable number of incompetent counselors.

After this very brief and hurried pointing to a few of the growing number of research investigations in this area, I would like now to turn to a description of these three central skills.

That an accurate and sensitive awareness of the other person's feelings, aspirations, values, beliefs and perceptions, that a deep concern for the other person's welfare, without attempts to dominate him, and an open nondefensive, nonphony genuineness prove beneficial in any human interaction has long been recognized by philosophers, novelists and by authors, and theoreticians in psychotherapy, counseling, and indeed the broad areas of human relationships. The first systematic theoretical view focusing upon these central characteristics was proposed by Shoben (1953) from the learning theory orientation. The next major comprehensive theoretical statement focusing on these characteristics was by Bordin (1955) a counseling theorist, while the highly organized theoretical statement by Rogers (1957) marked a point of theoretical convergence for virtually all theorists within the main stream of thinking about therapeutic interpersonal relationships heavily underscored empathy, warmth, and genuineness. It must, however, be noted that Freud, Fromm-Reichmann, Otto Rank, Alfred Adler, and virtually all of the phenomenologically oriented psychoanalysts as well as current behavioristically oriented theorists and therapists have agreed to the theoretic and clinically importance of these skills (reviewed in Truax and Carkhuff, 1967).

That these qualities are essential not just for therapeutic relationship but more generally for the growth of the self of the individual, is underscored not only by therapists but by such philosophers as Martin Buber (1953) when he says, "for the inmost growth of the self is not accomplished, as people like to suppose today, in man's relation to himself, but in the relations between the one and the other...in the making present of another self and in the knowledge that one is made present in his own self by the other..." (p. 249).

Clearly, the essential aspects of accurate empathic understanding, nonpossessive warmth, and genuineness are the common property and knowledge of all humanity. We do not have complicated research scales

at our finger tips when in our everyday life we respond positively to the very human nonpossessive warmth and caring experienced from one and respond negatively and perhaps defensively to the ungenuine, phony, defensive qualities displayed by another person. What goes into our perception and response of being understood as ourselves rather than as an object by fellow human beings? It is significant that we are able to recognize these qualities in others when we encounter them. While the complicated research scales are useful both in research and in training, a recent study initiated by Shapiro (1967) compared estimations with degrees of these interpersonal skills exhibited in tape recorded conversations when they were evaluated by carefully trained raters using the scales and when they were evaluated within a ten second period by untrained people. The findings indicated relatively close agreement -- over half of the variability in the actual evaluations were in agreement (correlations of above .70). Perhaps it is simply because as our research has shown, that empathy, warmth, and genuineness are human qualities and cannot be effective when they are "professionalized" in any rigid manner. When they become professional rather than human qualities they are not effective in producing positive human behavior and personality change.

Although our research evidence currently available suggests that for effective interpersonal impact one must not be decidedly low on any of the three qualities and be moderately high on at least any two of them, the order in which I wish to discuss them does have some special significance.

To be facilitative toward another human being requires that we be deeply sensitive to his moment to moment experiencing -- grasping both the content and the meaning of his experiencing, feelings, beliefs and values. But such a deep and receptive empathic understanding requires that we at least experience a minimal degree of warmth and respect for him without attempts to dictate to him or dominate him. Thus, deep understanding seems impossible in the face of hostile rejecting or unreceptive attitudes. It is as difficult for individual persons as it is for nations to understand in an empathic manner those they dislike, and those who are enemies. In turn, and most basically, empathy and warmth could not be constructively meaningful unless it were given by a person who was at least minimally "real". Even if it were possible to be experiencing warmth and understanding from an unpredictable phony or a strongly defensive individual (including a potential enemy) it would seem likely to be more threatening than facilitative. In this sense, genuineness or authenticity or nondefensiveness is most basic to a human relationship. It is this that makes a trusting and open relationship possible. Once this is established then nonpossessive warmth provides the nonthreatening context and the positively motivating context of a relationship. Finally, the moment by moment empathic grasp of the meaning and significance of the

other's world can lead to the "work" of changing another person by any dialogue or manner we communicate our understanding and force him to openly understand and accept himself -- both his current behavior, his pride and shame of past behavior, and his hopes and fears for his future behavior.

Although we believe on the basis of current evidence that the effectiveness of accurate empathic understanding in producing or eliciting positive human behavior change depends on a warm and nondefensive authentic or genuine relationship, this does in no way imply that the helping will first be genuine then develop a feeling of warmth and finally be better able to be empathic. It seems that in practice quite the reverse is true. Most often we come to warmly value, prize, respect or like another person as we listen to him and discover the nature of his phenomenological world. As we understand his private world and hence the meaning of objective events for him, we increasingly are able to more easily and freely be <u>ourselves</u> in the relationship.

As we come to know some of <u>his</u> wants, some of <u>his</u> needs, some of <u>his</u> achievements, some of his failures, and some of his values, we find ourselves living with the other person as much as we do with the hero or heroine of a novel. It is in this crucial sense that the psychoanalytic view of empathy as a process of "trial identification" has great meaning for effective interpersonal skills. Just as with the character in the novel, we come to know the person from his own internal viewpoint and thus gain some understanding and flavor of his moment by moment experiences. We come to see events and significant people in his life as they appear to him -- not just as they objectively are, but instead as he experiences them. As we come to know him from his own personal vantage point we seem automatically to sympathize with his mode of existence and come to value and like him. Perhaps precisely because we are concentrating on his experience we are much freer from our own threat and insecurity and so in those moments can become more authentic and more genuinely ourselves. Thus, it seems that as we begin to receive and understand the events and experiences and feelings of another person's existence "as if" they were parts of our own life, we come to feel warmth, respect, and liking for a person who, in an objective sense, may be weak, cowardly, treacherous, vile or despicable. Indeed, few modern novels choose as central characters impeccable paragons of virtue -- most often they are even more weak, cowardly and despicable than ourselves.

Thus, as with the hero of novels, we come to know, and value, and warmly respect another not simply because he is good, exemplary, or what we ourselves would like to be, but instead because we understand him and his life experiences from the internal vantage point rather than from an external objective viewpoint.

What do we mean when we say that a person is acting himself, is integrated, authentic, nondefensive, or genuine? We mean that he is a real person in an encounter presenting himself without defensive phoniness, without hiding behind a professional facade or other role. The helping person is himself, but this does not mean that he will act or behave as he does at home with his family or as he does in many other situations. May (1958) put it well when he said that the therapeutic person was real in the way that a midwife is real -- completely real in being there but being there with the specific purpose of helping the other person to bring to birth something from within himself. In an attempt to describe the clinical meaning of genuineness in the practice of counseling or therapy, Rogers and Truax (1967) say "so if I sense that I am feeling bored by my contacts with this client and this feeling persists, I think I owe it to him and to our relationship to share this feeling with him. The same would hold if my feeling is one of being afraid of this client, or if my attention is so focused on my own problems that I can scarcely listen to him. But as I attempt to share these feelings I also want to be constantly in touch with what is going on in me. If I am, I will recognize that it is my feeling of being bored which I am expressing, and not some supposed fact about him as a boring person. If I voice it as my <u>own</u> reaction, it has the potentiality of leading to a deep relationship. But this feeling exists in the context of a complex and changing flow, and this need to be communicated, too. I would like to share with him my distress at feeling bored and the discomfort I feel in expressing this aspect of me. As I share these attitudes I find that my feeling of boredom arises from my sense of remoteness from him and that I would like to be more in touch with him and even as I try to express these feelings, they change. I am certainly not bored as I await with eagerness and perhaps a bit of apprehension for his response. I also feel a new sensitivity to him now that I have shared this feeling which has been a barrier between us. I am very much more able to hear the surprise or perhaps the hurt in his voice as he now finds himself speaking more genuinely because I have dared to be real to him. I have let myself be a person -- real, imperfect -- in my relationship with him."

The measurement (Truax, 1962a) of therapist genuineness from recorded psychotherapy sessions used a scale descriptively specifying stages along a continuum. At its lowest level the scale includes such descriptions as "....there is explicit evidence of a very considerable discrepancy between his experiencing and his current verbalizations", and "....the therapist or counselor makes striking contradiction in his statements .... or, the therapist may contradict the content .... with the voice qualities ...." At intermediate stages on the continuum "the counselor or therapist responds .... in a professional rather than a personal manner .... there is a somewhat contrived or rehearsed quality ...." At higher values on the continuum "there is neither implicit nor explicit evidence of defensiveness or the presence of a facade", and at the highest level "there is an openness to experiences and feeling by the therapist of all types -- both pleasant and hurtful -- without traces of defensiveness or retreat into professionalism...."

In daily life each of us can think of persons who are transparent and genuine, who are what they seem. This is the quality of genuineness.

Perhaps a large part of the reason for the effectiveness and central importance of genuineness lies in the fact that our own openness and personal freedom from defensiveness in a therapeutic encounter provides a model for the other person to follow in moving towards openness and freedom to be himself. Stating this negatively, we might ask "can we expect openness, self-acceptance, andpersonal freedom from defenseiveness in another person when we ourselves lack these qualities in a relationship?"

Nonpossessive warmth or a warmly receptive nondominating attitude, though separable from the other central skills in effective interpersonal relationships, inevitably overlaps and intertwines with the communication of accurate empathy and genuineness. Thus, Raush and Bordin (1957) in an excellent theoretical analysis of the components of warmth specify the commitment of the person, his effort to understand, and his spontaneity. Our own research has also indicated that the intensity and intimacy of a relationship are strongly related and overlaps with warmth. Another overlapping aspect of warmth involves the concept of psychological distance; the more distant the relationship, or the more aloof we are in a relationship, the less warmth we communicate. Warmth does not imply passivity or unresponsivity; nonpossessive warmth is an outgoing positive action involving active personal participation.

A careful cataloguing of the kinds of behavior and verbalizations that people use to communicate a nonpossessive warmth could easily fill a number of books. Warmth and respect can be communicated or not communicated in a variety of ways. It does involve an acceptance of what is, rather than a demand for what ought to be. To return to the analogy of the reader who identifies with the hero of a novel, as readers will become engrossed in following the actions and feelings of the hero without having to personally agree or disagree, approve or disapprove of his feelings and actions, in much the same way when we are engrossed in reading or understanding another person, we would have to stop and disengage ourselves from the relationship to feel or voice our agreements or disagreements, approvals or disapprovals of what lies in him. This does not mean a namby-pamby or sentimental acceptance of undesirable behavior, since the other person himself does not value all of his actions. Thus in working with college underachievers a good counselor can communicate very high levels of warmth and, at the same time, be able to confront the underachiever with the fact of his own laziness. Not as a socially desirable or socially undesirable trait, but simpy as what is.

From another point of view, it may be that our ability to experience warm positive feelings for another person depends basically on our ability to feel a receptivity and warmth for our own self -- an openness to both the good and bad that lives in us. Both clinically and from research evidence there appears to be a fairly direct relationship between one's own self regard and the regard felt for others, (Fey, 1955; Kanfer and Marston, 1963).

The measurement of nonpossessive warmth (Truax, 1962b) specifies a continuum involving at the lower range such helping behaviors as (he) acts in such a way as to make himself the locus of evaluation .... (he) may be telling the patient what would be 'best' for him, or may be in other ways actively trying to control his behavior, or, the therapist "responds mechanically to the client and thus indicates little positive warmth .... or .... ignores the patient where an unconditionally warm response would be expected -- complete passivity that communicates a lack of warmth". At very high values "(he) clearly communicates a very deep interest and concern for the welfare of the patient. Attempts to dominate or control the patient are for the most part absent .... except that it is important that he (the patient) be more mature .... or that the therapeutic person himself is accepted and liked, "or at the highest level .... the patient is free to be himself even if this means that he is temporarily regressing, being defensive, or even disliking or rejecting the therapist himself".

Accurate empathic understanding involves the ability to <u>perceive</u> and <u>communicate</u> accurately and with sensitivity both the feelings and experiences of another person and their meaning and significance. Through a process of trial identification we step into the other person's shoes and view their world from his emotional and perceptual vantage point. Because we cannot truly be another person, we can be both "inside" another person and yet also remain "outside" which allows us to sense the meaning of another person's anger, fear or joy, its antecedents and its consequences, without ourselves being overwhelmed by the experiencing. This allows us to contribute to the expansion and clarification of the other person's own awareness of his experiences and feelings. This is the essence of the fine balance between identification with the other person and objectivity that is the hallmark of an accurately empathic person. Being empathic we assume the role of the other person, and in that role initiate ourselves the process of self-exploration as if we were the other person himself. In dealing with the disturbed person, it is as if we were providing a model for him to follow, as if we were saying by our example "even fearful or terrifying experiences or feelings are not so terrible that they cannot be touched and looked at".

Intense focusing on the other person, of course, is central to the perceptive aspect of deep empathic understanding since it allows us to note subtle nonverbal communications -- the minute facial, postural, and gestural clues that often contradict or magnify the meaning of another person's verbal communications. This intense focusing on the

other person also tends to ensure that errors in either our own perception or communication of understanding will be quickly recognized. We will be able to sense from his often subtle responses when our own communications do not fit exactly and, sometimes in midsentence, we can shift to correct for errors of language or content. In short, our intense and intimate focus on the other person makes possible the moment to moment contact necessary for accurate empathic understanding.

As we have all learned in life, people are not always what they seem. All of us have been conditioned from childhood to present social facades so that we often say in a polite manner when we are insulted or hurt and are asked about it, "oh no, that doesn't matter". Even with a minimal empathic grasp the other person should be able to see that it does indeed bother us a great deal. Thus, to be empathic we must separate the meaningful communications from another person from those arising from a defensive screen or social facade.

As the term empathy implies, many of the cues used for deciding what is true, and what is false, and what is meaningful in things we hear from another person come from the root ground of our own experience and existence. We can often recognize from our own awareness of ourselves the outward signs that relate to inner feelings and experiences. Beyond this, we learn about the human condition from our success and our failure in understanding others as well as from our reading of outstanding novelists and theoreticians of human behavior. Most basically, of course, we rely upon the moment by moment changes in the other person as to what is most meaningful. The moment by moment changes in the other person alerts us to our own clumsiness, when intended understandings are misperceived as insults, slights or deprivations. Thus, hurried and empty laughter can communicate as deeply and as clearly as moistened eyes: the overly strong denial tells us as much as the halting and strained confrontation. Often a blush, stammer, a flood of words, a change in breathing, a tensing of posture or the lack of socially appropriate feeling may be much more important than what the other person at that moment is saying in words.

In one sense we help clarify another person's understanding of himself by serving as a mirror to his emotional and phenomenological self. Just as he learns about his physical self by seeing his image reflected in a mirror, he learns about his emotional and phenomenological self by hearing these aspects of him reflected by us.

The accurately empathic therapeutic person not only indicates a sensitive understanding of the patient's <u>apparent</u> feelings, but goes further to clarify and expand what is hinted by voice, posture and content cues. The Accurate Empathy Scale (Truax, 1961), defines a continuum which specifies at its lower values such behaviors as "(he) seems completely unaware of even the most conspicuous of the patient's feelings. His responses are not appropriate to the mood and content of the client's

statement and there is no determinable quality of empathy, hence no accuracy whatsoever". Whereas, at intermediate levels of the continuum he often responds accurately to more exposed feelings. He also displays concern for more hidden feelings which he seems to sense must be present, though he does not understand their nature. "Or, he shows awareness of many feelings and experiences which are not so evident ... but in these he tends to be somewhat inaccurate in his understanding." At the higher levels of the continuum of accurate empathy, the therapist "shows awareness of the precise intensity of most underlying emotions ... his responses move only slightly beyond the area of the client's own awareness, so that feelings may be present which are not recognized by the client or therapist," or "accurately interprets all of the client's present, acknowledged feelings. He moves into feelings and experiences that are only hinted at ... and does so with sensitivity and accuracy. (He) offers additions to the patient's understanding so that not only are underlying emotions pointed to, but they are specifically talked about." To both accurately predict and effectively communicate what the client or patient is currently experiencing and feeling and therefore, of "what the patient <u>might well say</u>, were he more open and less defensive", is the quality of accurate empathic understanding.

Thus, the essence of nonpossessive warmth is to preserve the client's self respect as a person and a human being and to provide a trusting, safe atmosphere; the purpose of genuineness is to provide an honest nondefensive relationship which allows us to point to unpleasant truths about the relationship and about the client rather than to hide behind a defensive screen or ourselves offer rationalizations to make the client's behavior more socially acceptable; while the purpose of accurate empathy is to facilitate the client's self-exploration and to maintain a moment by moment contact in the relationship.

How do these interpersonal skills function in a relationship? What are some of the specifics that are now known?

First, we might note that the research evidence clearly indicates the functional independence of empathy, warmth, and genuineness. Thus, while the three scales tend to be positively intercorrelated across the wide variety of therapists or helpers, in some subsamples of counselors or therapists studied we find negative correlations (for example, between empathy and genuineness and between empathy and warmth, and between warmth and genuineness). Further, we know that we can experimentally manipulate empathy and warmth without causing parallel directional changes in genuineness.

Secondly, we know that although there is a moment to moment variation in these interpersonal skills as they exhibit themselves in a

relationship, there is no systematic increase or decrease over time in therapy. This tends to emphasize the momentary character of these interpersonal skills. Surely at the outset we expect that empathy would tend to increase the longer the time spent in the relationship. That this does not happen clearly underscores the momentary nature of the empathic process.

In particular studies aimed at therapeutic strategy we have discovered that the lowest levels of warmth and genuineness and the mean levels of warmth and genuineness predict outcome quite well, but the highest or altitude levels do not predict. Clinically, this suggests that the therapist should not be concerned about his highest moments of warmth and genuineness but be careful not to offer at any point seriously low levels of warmth and genuineness. It looks as if once a therapist provides quite low levels of these qualities, then the client will no longer trust the relationship. By contrast, with accurate empathy it is the highest or altitude levels and the mean levels that predict and not the basal levels. Clinically, this suggests that we can be most therapeutic by attempting deep empathic responses even at the risk of being wrong, as long as our average is relatively high. This means the client can easily forgive the occasionally inept or totally unempathic response as long as he is generally understood and especially if he is at moments deeply understood.

One of the surprising findings in studying therapy with college underachievers was the discovery that higher levels of interpersonal skills were needed for such a population than for the more disturbed patients. Of course, we had expected just the opposite. The field, as a whole, tends to assume that the very best therapy is necessary for the severely disturbed patient and relatively poorer quality therapy is sufficient for the mildly disturbed client. As it turns out, there is some evidence to suggest that for effective therapy to produce personality and behavioral change quite the reverse is true; we need more empathic, warm and genuine therapists with the less disturbed client than we do with the severely disturbed client. Along the same line it is clear that where rejection is expected, as in the case of white therapists or counselors interacting with Negro clients, unusually high levels of therapeutic skills are required for client progress.

Before closing this chapter we should perhaps consider briefly the ways in which empathy, warmth, and genuineness may operate to produce human behavioral and personality change across the broad spectrum of human types and situations. While certain knowledge of their mode of operation in producing desired behavior changes in clients must await further research, some tentative explication can be suggested.

First, the therapist's offering of accurate empathic understanding, nonpossessive warmth, and genuineness to the patient provides a safe or non-threatening relationship which minimizes or reduces the presence of threat, which in turn minimizes the patient's defensiveness and inhibition. Experimental evidence is abundantly available to indicate that threat increases anxiety which in turn interferes with complex learning.

Secondly, the offering of these high levels of conditions, through the principle of reciprocal effect, induces positive feelings on the part of the client which co-vary with the warmth, etc., offered by the therapist. From recent evidence (Bandura and Perloff, in press, Journal of Personality and Social Psychology, 1967) it is clear that a person's self reinforcement system is at least as effective as an externally imposed reinforcement system. The crucial importance of the patient's self-concept system lies in its control of his reinforcement system, which in turn markedly affects his behavior (as suggested by Marston, 1965). The presence of high conditions tends to elicit and reinforce self concepts and also to foster positive expectations or induce hope, which as expectance studies and placebo studies have shown, have significant effects on a person's behavioral functioning.

Thirdly, as recent research has shown accurate responses involve a high degree of implicit and explicit confrontation (Berenson and Mitchell, 1967, unpublished) this, and the verbalization of the fact that the person is not functioning maximally, demands a commitment for change from the patient.

Fourthly, these interpersonal skills of empathy, warmth, and genuineness have shown to have powerful reward value or reinforcing properties (Truax, 1966a, 1967b) and can therefore be used selectively in the specific shaping of the client's behavior.

Fifthly, the offering of high conditions provides a model of an effective therapist which the evidence on modeling and imitation learning (Bandura, 1965) suggests will induce direct behavior change.

Sixthly, warmth as Shoben (1948, 1949) and others have noted has potent counterconditioning value in the extinguishing of a person's fear, anxiety, and learned avoidance and defensive reactions involved in human interpersonal relating. Particularly, non-possessive warmth, through the principle of reciprocal affect, tends automatically to also elicit warmth and comfort responses in the patient; a response incompatible with an anxiety or defensive response. As the patient becomes conditioned to the new response of elicited warmth, this response competes with anxiety, avoidance or defensiveness cues associated with interpersonal relating.

Seventhly, the high levels of therapeutic conditions and accurate empathy in particular lead to cognitive changes via the client's self-labeling or insight of "what leads to what". Either self-labeling by the client or by the therapist as Mowrer (1939), Dollard and Miller (1950), and Farber (1963) have noted, facilitates awareness of response-reinforcement contingencies and thereby influences the client's overt performance. The research of Dulaney (1961), Erickson (1962), and Farber (1963) strongly indicates that empathic responses promoting recognition of response-reinforcement contingencies are effective in producing desired behavior changes.

Finally, studies in mass communication, opinion change, and persuasion both in small group processes, police confessions, and mass public opinion change indicate that the higher the level of personal involvement between communicator and recipient, the higher the degree of group cohesiveness, (the warmer and more empathic the communication), the greater the degree of opinion change or persuasion in the recipient (Zimbardo, 1960; Winthrop, 1958; Berkowitz, 1954; van Zelst, 1951; Schacter, Ellertson, and McBride, 1951; and French and Snyder, 1959).

While there is scattered evidence suggesting the value of other personal and impersonal factors in the counseling process related to what the effective counselor actually does when seeing a client, such evidence is fragmentary and incomplete. There is evidence, for example, to suggest that it is helpful to structure the relationship to the client by letting him know what to expect, what he is to do, and what to expect from the counselor (Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle, 1963; Truax and Carkhuff, 1965; Truax and Wargo, 1966a; Truax, Wargo and Carkhuff, 1966; Vernallis and Reinert, 1961). In a sense, the converging evidence on the value of both experiential and cognitive structuring fits well with what is known about human learning. If counseling is indeed a process of learning and relearning, then the therapeutic process itself should allow for structuring what is to be learned, rather than depending on what amounts to "incidental learning", where the client does not have clearly in mind from the outset what he is supposed to learn.

There is also evidence to suggest the value of direct behavior modification when it is carried out within the context of an effective interpersonal relationship. The behavioristic approaches suggested by Bandura (1965), Eysenck (1960), Krasner (1962), Wolpe and Lazarus (1966) have received support from available research evidence. The evidence, however, is not nearly so strong nor so systematic as would be desirable. Indeed, there is conflicting evidence suggesting limitations on these procedures (Marks and Grelder, 1966).

Toward Selection of Effective Counselors

Since the interpersonal skills of accurate empathy, nonpossessive warmth, and genuineness seem central to effective counseling, the selection of trainees to become potential rehabilitation counselors as well as, where possible, the selection of rehabilitation counselors for employment should focus in part upon the counselor's interpersonal ability in this area. Although research evidence does suggest that these essential therapeutic skills can be improved with training, it must also be clear that the lifelong experience of relating to other human beings is likely to be prepotent in determining the way counselors respond to their very human clients. In a sense, we can think of the counselor's way of responding to clients as a result of overlearned habits of relating: while training can improve the quality of interpersonal relating, the effects may well be transient and impermanent in counselors or potential counselors who, for a lifetime, have related to others in an unempathic, cold, aloof and defensive manner.

Ordinarily, supervisors in counseling and psychotherapy tend to select potential trainees on the same bases that they select patients or clients: intelligent, verbal, well-motivated, high socioeconomic status, high ego-strength, etc. In part, current selection procedures derive from the fact that solid evidence for selection has been largely non-existent. A supervisor does not know a "good prospective therapist" from a poor one, except in terms of very private norms and experience.

Some studies, such as that by Combs and Soper (1963), attempted to discriminate between attitudes held by good and poor counselors. Although their findings indicated that better counselors were those who tended to assume an internal rather than external frame of reference in understanding others, who were people-oriented rather than thing-oriented, and who had an optimistic view of man, solid criteria of counselor effectiveness were lacking. In their data, as in most cases, the definition of counselor effectiveness were lacking. In their data, as in most cases, the definition of counselor effectiveness was based upon their supervisor's ratings. The Bergin and Solomon (1963) study, however, did investigate a number of correlates of empathic ability, which seem to have relevance to selection. Their data indicated that within the restricted range of intelligence occurring in graduate school students, there was a nonsignificant negative correlation with verbal intelligence (-30) and, equally surprising, a nonsignificant negative correlation (-18) with the "psychologist" subscale of the graduate record exam. Their findings also indicated that personality was significantly associated with empathic ability: they found negative relationships with test indicators of person-

ality disturbance (such as the Psychasthenia scale and Depression scale as of the MMPI) and positive relationships with measures of personal strength (the Dominance and Change scales of the Edwards Personal Preference Schedule). Also of importance, empathic ability seemed to be negatively related to a cognitive orientation, as measured by in Order and even Intraception on the Edwards Scale.

The study of the 16 students receiving the present approach to training (Truax, Silber, and Wargo, 1966), also yielded some information of suggestive value for the selection of potential trainees. Personality inventories were administered to the group of students before and after training, and were then compared with their learning achievement. That is, using the measures of their actual ability to communicate accurate empathic understanding, nonpossessive warmth, and genuineness early and late in the training program, those students who showed the most gain in ability, were compared on a number of personality variables with those students who showed the least improvement in therapeutic skills. Here, then, the questions posed were, " what kind of trainee benefits the most from the training program?" and "What personality changes occur in trainees who change the most compared to those trainees who show little gain in therapeutic skill?"

Some of the findings fit well with the Bergin and Solomon (1963) findings. Bergin and Solomon found a negative relationship between Need for Order (on the Edwards Scale) and empathic ability, among the students in the present training program, those who showed the greatest gains in the therapeutic conditions were initially slightly lower on Need for Order than those who showed little or no gain, and they showed a significant drop in post-training, while those who showed the least improvement in therapeutic skill showed no change in Need for Order. The Bergin and Solomon data showed significant positive association between the Change Scale and Empathic ability; those students who showed the greatest gain in the therepeutic conditions in the present training program were significantly higher on the Change Scale, both pre and post, both before and after training, than those who showed least gain, and there was a nonsignificant tendency during training for the most number improved to increase on the Change Scale and for the least number improved to decrease.

The Bergin and Solomon data indicated a nonsignificant negative association between empathic ability and Abasement on the Edwards and those who gained most and least from the present training program were equivalent on the Abasement Scale before therapy, but the most improved students showed a significant decline during training, while the students who showed least gain in therapeutic skill showed an increase in the Abasement Scale. The Bergin and Solomon data indicated a positive correlation between the Autonomy

Scale and empathic skill; students who showed greatest gain in the present training program started off significantly higher and showed large and significant gain in Autonomy and showed negative change. Finally, the Bergin and Solomon data indicated nonsignificant negative association between the Defensiveness scale on the Edwards and empathic ability; the findings in the analysis of students in the present training program indicated that those students who showed the greatest gain in therapeutic skill were initially significantly lower on Defensiveness, while both groups of students showed a decline in Defensiveness during training. A summary of the findings are present in Table 1.

Table 1

Summary of Findings on Personality Correlates of Therapeutic Conditions for Therapists

	Bergin and Solomon 1963	Truax, Silber and Wargo 1966b	
MMPI	Initial	Initial	Direction of Change with Training
Pt scale	low*	low*	lower*
D scale	low*	low*	lower*
Mf scale	low	curvilinear*	higher*
Ma scale	low	average best curvilinear*	higher*
Si scale	low	average best low*	lower*
Welsch's A.L. Index	not scored	low*	lower*
Welsch's I.R. Index	not scored	low*	lower*
Constructive Personality Change Scale	not scored	high*	higher*
Edwards Personal Preference Schedule			
N Defensiveness	low	low*	lower
N Dominance	high*	high	lower
N Change	high	high*	higher
N Order	low*	low	lower*
N Intraception	low*	low	lower
N Abasement	low	no relationship	lower*
N Autonomy	high	high*	higher*
N Conformity	low*	low	lower*

* Significant at or beyond .05 level

These findings dealing with initial personality measures for "successful versus unsuccessful trainees" are only suggestive for trainee selection, since both Bergin and Solomon (1963) and the Truax, Silber and Wargo (1966) data are based on small samples. However, the agreement between these two studies made with widely different student populations and training approaches is at least encouraging. More importantly, the Truax, Silber and Wargo data dealing with personality change of students during training in psychotherapy provide evidence that the changes in ability to communicate therapeutic conditions made during the present training program were not "only skin deep". Those students who showed significant gains in therapeutic (or interpersonal skills) also showed relevant, positive personality change.

Quite recently (unpublished), a third study tends to suggest the importance of the same personality dimensions.

A very simple procedure for selection of rehabilitation counselors for employment in facilities could easily be used without the problems involved in personality testing. Quite simply, a potential counselor could be asked to interview for ten to fifteen minutes each four or five different randomly selected clients. The counseling sessions could be tape-recorded and then evaluated by supervisory or administrative personnel to ensure that the rehabilitation counselor being employed is able to, at least, offer minimally high levels of empathy, warmth and genuineness to the clients he will be seeing. This procedure has much to recommend since there is evidence to suggest that a counselor may be more able to offer high interpersonal skills to one type of client population than another. It is also enormously more predictive of counseling effectiveness than an attempt to evaluate interpersonal skills only on the basis of the potential counselor's ability to relate to supervisors and peers.

An Approach to Effective Counselor Training

The majority of the research studies assessed the levels of empathy, warmth, and genuineness by the use of these research scales developed for use with tape recordings of actual counseling or psychotherapy. As was suggested four years ago, (Truax, 1963) the rating scales themselves can be used in a didactic manner for training beginning therapists. An approach to training, using the research scales in an integrated didactic and experiential program, has been described (Truax, Carkhuff, and Douds, 1964; Truax and Carkhuf, 1967). This training program has been applied to several training groups, both at professional and nonprofessional personnel levels.

The three central elements in the training approach can be summarized as: (1) A therapeutic context in which the supervisor communi-

cates high levels of accurate empathy, nonpossessive warmth, and genuineness to the trainees themselves; (2) a highly specific didactic training using the research scales for "shaping" the trainees' responses toward high levels of empathy, warmth, and genuineness; and (3) a focused group-therapy experience which allows the emergence of the trainee's own idiosyncratic therapeutic self through self-exploration and consequent integration of his didactic training with his personal values, goals and life style.

While a complete description of the training program is contained in a book developed specifically for use in training and practice, (Truax and Carkhuff, 1967), a few brief comments about the use of the research scales should help to clarify the didactic nature of the training. The scales are used to identify tape-recorded samples of experienced therapists who are, in fact, offering very high levels of therapeutic conditions; thus, providing models for imitation. It should be remembered that even the best recordings of total sessions usually provide a number of examples of precisely what not to do. Secondly, the trainees are taught the use of the scales so that they will learn to identify high and low levels of empathy, warmth, and genuineness in their own therapy and in that of others. Thirdly, "empathy training", "warmth training", or "genuineness training", is provided by placing a tape recording of patient talk and then requiring trainees to make immediate "therapeutic responses" which are immediately rated on the research scales to provide prompt feedback. As they "shape" their responses toward higher levels of empathy, warmth, and genuineness, they begin role playing which, in turn, is recorded, brought to class, and rated by a group of trainees on the research scales. Thus, they compete among themselvesin ability to communicate these therapeutic conditions. Finally, they begin one-shot interviews with real clients which again are tape-recorded and brought to class session for rating.

In all, <u>the complete basic training program involves less than 100 hours of training</u>.

There now exist a number of studies (viewed in Truax and Carkhuff, 1967) which indicate that trainees (both professional and non-professional counselors) can be brought to a level of interpersonal skill that is (1) nearly commensurate with that of highly experienced and effective counselors; (2) significantly above that of post-practicum and post-internship trainees in counseling and psychotherapy at major universities involved in doctoral training; and (3) effective in producing significant positive changes in mildly and severely disturbed clients. Taken together, the available evidence strongly suggests positive benefit for this approach to training.

More recently, the experience of the faculty and staff of the Arkansas Rehabilitation Research and Training Center suggests that more permanent and lasting effects on counselor behavior can be produced by periodic workshops or "seminars" for those who have completed a basic short-term training program: the effect is to reinforce the habit of relating to clients with high levels of interpersonal skills and to discourage the counselor's tendency to fall back on his life long style of relating to others when dealing in a professional role with clients.

Potential Roles for Supportive Personnel in Rehabilitation Counseling

Given the fact, the indisputable fact, that the number of vacancies continues to grow at a faster rate than the supply of professional trained personnel, and the additional fact that existing financial structure in many states is already seriously overburdened, it seems evident that supportive personnel will be utilized in growing numbers in rehabilitation counseling, and, indeed, in most all disciplines involved in the total vocational rehabilitation process.

Professional counseling organizations, including the National Rehabilitation Counseling Association, the American Personnel and Guidance Association, and the American Rehabilitation Counseling Association, and the division of counseling of the American Psychological Association, have urged that support personnel be utilized in the performance of clerical duty, job development duty, administration and scoring of aptitude tests, and other specific subfunctionings of the rehabilitation counseling role. The professional organizations have over the years demanded higher academic credentials in their professional standards. In particular, professional organizations have argued against the use of support personnel to in any fashion replace professional counselors. Instead, they have urged heavier financing to expand professional training and educational programs and recruitment of students. Even under close supervision, the position of professional organizations argues that the high level of professional training and supervised experience is necessary for effective rehabilitation, hence, support personnel must restrict themselves to "simpler" tasks that the counselor has decided are of value for his client.

Despite all this, agencies and facilities have utilized counselor aides, under supervision, in all aspects of the counseling process, and in some case, counselor aides have taken over almost the complete role of the professional counselor.

In a rough fashion, supportive personnel functioning as counselor aides can potentially work under two conditions: 1) as an assistant to a professional counselor to assist where needed in the provision of services for the counselor's own case load, and 2) under close supervision, to function as a counselor in providing services to the counselor-aide's own case load.

Effects of Supportive Personnel in the Role of Counselor-Aides

In an effort to provide some solid evidence, the Arkansas Rehabilitation Research and Training Center and the Hot Springs Rehabilitation Center have, over the past fourteen months, been conducting research aimed at evaluating the effects of support personnel in rehabilitation counseling.

In the ongoing study, counselor aides were recruited as secretaries, and, without training, assumed varying degrees of responsibility in the rehabilitation counselor role.

The design of this study was quite simple: clients in the Hot Springs Rehabilitation Center (they are called students there) were randomly assigned to counselors or counselor aides in one of three experiemental conditions; (1) a counselor working alone in the traditional manner; (2) a counselor assisted by a counselor aide being utilized under maximal supervision; and (3) a counselor aide who under daily supervision functioned in the complete role of counselor. Additionally, under each of these three conditions counselors and counselor aides were randomly assigned to having high and low case loads: the high case load condition handled twice as many clients as the low case load condition.

Thus, with random assignment clients of equal difficulty or severity were seen under each condition.

Additionally, counselors, counselors plus aides, and aides alone after an initial period of adjustment and on-the-job training held regular weekly group counseling sessions with all of their assigned clients. Since the inception of this study, records of the client's vocational rehabilitation progress have kept daily diaries indicating the actual client contacts, length of contacts, and reason for contacts. Finally, all group counseling sessions were tape-recorded and have been analyzed to evaluate the level of accurate empathy, nonpossessive warmth, and genuineness offered to clients by both professional counselors, counselors and aides seeing the same case, and aides functioning in the counselor role with daily supervision.

Before turning to the current findings in that ongoing study, it would be well to keep in mind the fact that counselors and counselor

aides worked together on a one-to-one relationship so that informal and highly meaningful supervision occurred from the outset. The counselors and counselor aides reported no difficulty in role relationship since a counseling aide was assigned to a specific counselor. Administratively, there was a vertical rather than horizontal relationship between counselors and counselor aides. The counselor aides were hired at a secretarial level of salary and regardless of their competency it was well understood that they were counselor aides and would not at any point in the future be upgraded to the level of counselor. Indeed, the practice of some agencies of attempting to upgrade support personnel to the level of a professional counselor on the basis of their ability makes no more sense than "promoting" the hospital orderly to a nurse simply because he has learned on the job to perform many, if not all, of the ward nurses duties!

Now to turn to the findings. The findings I will now discuss have to do with a total of less than four hundred clients, although to date many more have been seen by counselors, counselor plus aides, and by aides alone. We selected for the initial study only clients who have spent a majority of the year under one of the three counseling conditions. The measurement of client progress in vocational rehabilitation was obtained from the evaluation records of the Hot Springs Rehabilitation Center. These records included for each client evaluations of: (1) client work quantity or work production; (2) client cooperativeness; (3) client work attitude; (4) quality of client work; (5) client dependability; (6) client ability to learn; (7) client progress in course during last month; and (8) overall progress in course of training.

In spite of the fact that twice as many clients were being handled under the high case load condition than under the low case load condition, the level of case load had no significant effect on the client's performance or progress.

Differential effects of utilizing counselors alone in the traditional fashion, utilizing counselors and aides on the same cases, and utilizing the aides alone under supervision on their own case loads occurred on the client's progress as measured by his work quantity or work production, his work attitude, and his dependability. In each case, the best results were obtained by the aides working alone under the daily supervision of professional counselors. The professional counselors working alone had the second best results, while the counselor plus the aide working with the same individual cases had the poorest effects on clients. Indeed, on the other measures where no differential significant effect was observed, the differences that did exist were in the same direction. That is, from this evidence there was a slight tendency for the aides when functioning as counselors under the supervision of professional counselors but with their own separate case loads to have the most

benefit to clients. When an aide and a counselor jointly handled cases, the effects were somewhat worse than when either the aide or the counselor had their own individual case loads. In commonsense, everyday terms, it may be that too many cooks spoil the broth.

One other surprising set of findings from the studies thus far completed suggests that in terms of the measures of client dependability, client ability to learn, client progress in course during last month, and client overall progress in course, that the professional counselor had better effects under low case load management, while the aide had better effects with clients under high case loads.

Surprisingly, there was no tendency for different individual professional counselors or different individual aides to respond more favorably to one condition than another.

Another way of evaluating the effectiveness of the rehabilitation counseling process under high and low case load and conducted by the counselor, the counselor plus the aide, and the aide alone, was to obtain seven point ratings by the referring field counselor on the quality of counseling and case management for the clients he had himself referred to the Hot Springs Rehabilitation Center.

On this measure, the counselors and counselor aides having low case loads were evaluated as providing significantly greater understanding of the client, ability to influence the client, ability to predict problems, effectiveness in helping the client work out problems and arrive at decisions, effectiveness in helping clients with personal problems, effectiveness in helping the client choose alternative programs, and overall management of the case, than under high case load conditions. Thus, referring field counselors felt their clients were significantly more helpful when seen by counselors and counselor aides having low case loads than high case loads.

By contrast, when these same evaluations were analyzed in terms of whether the client himself was seen by a counselor alone, a counselor plus an aide, or an aide alone under supervision, there were no significant differences. If anything the nonsignificant differences again favored the aide working alone under daily supervision.

This latter finding occurred in spite of the fact that the majority of field counselors at the outset of the study did not have favorable expectations about the use of counselor aides. In essence then, the professional field counselor's evaluation of the case management of his clients was as high for the aides working alone under supervision as for the professional counselors working either alone or assisted by an aide.

When the tape-recorded sessions with clients were analyzed, a clue to the explanation for these disturbing and somewhat puzzling findings emerged. On the average, the aides working alone under daily supervision provided significantly higher levels of non-possessive warmth to their clients, and showed a tendency to provide a higher level of empathy. As with themeasures of outcome, when the counselor utilized an aide to assist him with his own case load, generally less warmth and empathy were communicated to the client.

As another important aspect of the data collection of this ongoing research project, daily diaries were kept by all counselors and counselor aides. On this diary for the rehabilitation case management project the daily contact with students and the actual contacts between the counselor aides and the counselor for supervisory or communication purposes were recorded daily. Thus, we have available for each day the names of the students seen by counselors or counselor aides, the reason, the number of minutes spent with each client, and whether or not this actually constituted "rehabilitation counseling". Since this project was carried out in a total residential facility, the counselors, counselors plus aides and aides alone under supervision saw students for a variety of purposes beyond those usually considered under any narrow definition of "counseling". Thus in the daily diary client contact for the following reasons were recorded: (1) request for room change; (2) clothing; (3) pass or leave violation; (4) special pass request; (5) drinking; (6) request of center staff; (7) training problem; (8) admission-discharge; (9) medical problem; (10) financial problems; (11) personal adjustment problem or relations with other students or staff; and (12) miscellaneous reasons.

From a series of analyses (Truax, 1967) other unexpected findings emerged. Thus, we found (in analysis of six months of rehabilitation counseling covering a hundred and nine counseling days) that the average counselor spent two thousand, one hundred and fifty minutes in contact with clients, the counselor plus aide working together spent an average of two thousand, eight hundred and twenty-five minutes in contact with clients, while the aide working alone under supervision spent an average of four thousand, five hundred and eighteen days. Thus, the aide working alone spent over twice the amount of time with clients as did the counselor working alone. It seems likely that this striking finding (significant well beyond the .001 level) was due to the enthusiasm of the aides and their motivation to spend time with clients.

When we look more closely at the time spent in various kinds of case management and counseling activities, the same general pattern emerged. Thus, in the time spent seeing clients for reason of personal adjustment problems or relations with other students or staff the same pattern emerges.

However, there was also a striking tendency for the counselors to spend less actual minutes in contact with clients when their case load was high, rather than low, while the aides spent over four times as many actual minutes in contact with clients when they had a high case load, than when they had a low case load, ($p < .001$). Thus, it appears that under high case load conditions, the aides are unusually motivated to see their clients (as if they were saying, "I have so many clients to see I had better get busy"), while the counselors were anti-motivated to see clients (as if they felt under high case "there are just too many clients to see, what's the use").

When the total number of minutes of actual "Counseling" was analyzed, the same pattern emerged with the aides alone spending almost twice as many minutes in rehabilitation "counseling" than the professional counselors alone ($p < .001$). Again, the aides working with their own case loads spent considerably more time counseling clients under high case load conditions than low, while the professional counselors working with their own caseloads spent considerably more minutes in counseling with their low case load clients than under high case loads.

In a large rehabilitation facility setting, counselors do not, of course, spend the same amount of time with each client nor do they see different clients with the same frequency. It therefore became of interest to analyze the data in terms of the number of student contacts occurring under the conditions of counselor alone with his own case load, counselor plus aide with the same case load, and the aide alone with his own case load. There were a hundred and forty-three student contacts by the counselor working alone, a hundred and seventy-six contacts by the counselor plus aide working together, and two hundred and thirteen contacts by the aide alone ($p < .05$).

These findings just reviewed occurred in spite of the fact that there was no significant difference under the three conditions in the average number of actual students counseled (as indeed was expected since under random assignment, the case loads were equivalent).

The differential effects on clients of the counselors working alone with their own case load, the counselor plus aide working on the same case load, and the aide under supervision working on his own case load were <u>not</u> due to the overall frequency of contacts, or of amount of time spent with clients, were indicated by further analyses looking specifically at the effects of frequency of client contacts and of number of minutes in client contact upon the measure of client progress in rehabilitation.

Overall, neither the total number of minutes spent in contact with individual clients nor the frequency of client contacts was related to client vocational progress. To repeat, neither the amount of time spent with the clients nor how frequently they were seen by counselors, counselors plus aides or aides alone was related to vocational progress.

Analysis of the data in terms of the reason for seeing the client shed some light on the nature of successful and unsuccessful residential vocational rehabilitation clients: those clients seen most frequently and for longer time for dealing with personal adjustment problems and for training problems showed poorest vocational progress: those clients seen most for leave (pass) violations or for drinking showed best vocational progress. This later finding might suggest that the motivated non-conformist, if dealt with by the counseling staff, makes better vocational progress than the conformist.

For the most part few differential effects of amount of time spent with clients by counselors, counselors plus aides and aides alone on client vocational progress occurred. However, clients made better progress in terms of work quantity if they were seen less frequently under the counselor plus aide situation but more frequently under the counselor alone or aide alone situation. This tends to suggest harmful effects of the use of counselors plus aides in handling the same case load.

From all analyses of project data, it would seem that the somewhat more positive effects on client rehabilitation when seen by aides under supervision working with their own case load (compared to counselors, or counselors plus aides) are due both to the somewhat higher levels of warmth and empathy communicated to clients by the aides and the greater motivation and enthusiasm of the aides (as indicated by spending more time with clients).

Suggestions and Implications

The available evidence does not support the position taken by professional counseling organizations. It would appear that using counselor aides to assist professional counselors in dealing with his own case load produces results somewhat poorer than the counselor working alone -- even with the same case load and equivalence of severity or difficulty of cases.

The findings do tend to strongly suggest that positive results are obtained when aides are individually assigned to counselors, work closely on a day-to-day basis with professional counselors but separately handle their own case load.

In view of the evidence concerning the central role of interpersonal relationships reviewed at the outset, and the findings that professionally trained counselors on the average do not gain greatly in interpersonal skills from traditional academic trainings, the findings concerning the effective use of supportive personnel in rehabilitation counseling are understandable. The counselor aides, of course, were chosen for their ability to relate, and it turned out that they provided significantly higher levels of nonpossessive warmth and tended to provide higher levels of empathy to their clients than did professional counselors who were selected primarily on the basis of academic professional credentials. As evidence accumulates, it is becoming clear that the human interpersonal relationship is central to the vocational rehabilitation process. It is perhaps time that university training programs focus more closely on this aspect of professional development.

Given the high level of training required for the professional practice of rehabilitation counseling, the complexities involved in the counseling process, and the extensive fund of expert knowledge required, it seems likely that under daily supervision supportive personnel can demonstrably increase not only the available manpower pool, but do so with increased client benefit if the administrative structure is vertical rather than horizontal and provides a one-to-one relationship between professional personnel and supportive personnel, but with the supportive personnel dealing relatively independently with his own case load.

It should, of course, be remembered that the generality of the present findings is at present unknown. With further research in other settings, a clearer picture will inevitably develop. However, because prior recommendations by professional organizations for the utilization of support personnel have been shown by careful research to yield the worse results in the present study, I am now willing to take the risk of applying the present findings to other settings. Indeed, on the basis of this long-term large scale study, I have become skeptical of recommendations by professional organizations in general -- when they are not based on solid research. It is even more disturbing to realize that recommendations of professional organizations, even when they are not based on solid evidence, can find their way not only into practice, but, even worse, into federal and state guide-lines that force recommendations into practice.

While generalization of the present findings to other disciplines is indeed hazardous, in view of the high level of training and complexity of practice in rehabilitation counseling, it seems at least plausible, if not probable, that similar findings might obtain for many other professional disciplines involved in the total vocational rehabilitation process.

Finally, the findings from this project clearly show a significant impact of the counseling staff working within a total residential rehabilitation center even though counseling staff-client contacts represent only a tiny fraction of the center staff contacts with clients. This project, then, has underscored the significant role of the rehabilitation counselor in the staffing of a complete center operation (even though they represent in numbers less than 5% of the manpower in a total rehabilitation center).

References

Adler, A. In Ruth L. Munroe, Schools of Psychoanalytic Thought. New York: Dryden Press, 1955, 509-510.

Aspy, D. N. "A Study of Three Facilitative Conditions and Their Relationship to the Achievement of Third Grade Students". Unpublished doctoral dissertation, University of Kentucky, 1965.

_____, and Hadlock, W. "The Effect of Empathy, Warmth and Genuineness on Elementary Students' Reading Achievement". Unpublished thesis, University of Florida, 1966.

Baldwin, T. and Lee, Joan. "Evaluation of Programmed Instruction in Human Relations". American Psychologist, 1965, 20, 489. (Abstract)

Bandura, A. and Perioff, B. "Relative Efficacy of Self-Monitored and Externally-Imposed Reinforcement Systems". Journal of Personality and Social Psychology, in press, 1967.

_____, and Walters, R. H. Social Learning and Personality Development. New York: Holt, Rinehart and Winston, Inc., 1965.

Berenson, B. G. and Mitchell, K. M. "Level of Therapist Functioning, Frequency and Type of Confrontation". Unpublished manuscript, Arkansas Rehabilitation Research and Training Center, University of Arkansas, 1967.

Bergin, A. E. and Solomon, Sandra. "Personality and Performance Correlates of Empathic Understanding in Psychotherapy". Paper read at American Psychological Association, Philadelphia, September, 1963.

Berkowitz, L. "Group Standards, Cohesiveness, and Productivity". Human Relations, 1954, 7, 509-519.

Betz, Barbara J. "Bases of Therapeutic Leadership in Psychotherapy with the Schizophrenic Patient". American Journal of Psychotherapy, 1963, 17, 196-212. (a)

_____, "Differential Success Rates of Psychotherapists with 'Process' and 'Non-Process' Schizophrenic Patients". American Journal of Psychiatry, 1963, 11, 1090-1091. (b)

Bordin, E. S. Psychological Counseling. New York: Appleton-Century-Crofts, 1955.

Buber, M. "Distance and Relation". Psychiatry, 1953, 16, 249.

Combe, A. W. and Soper, D. W. "The Perceptual Organization of Effective Counselors". Journal of Counseling Psychology, 1963, 10, 222-226.

Dickenson, W. A. and Truax, C. B. "Group Counseling With College Underachievers: Comparisons With a Control Group and Relationships to Empathy, Warmth and Genuineness". Personnel Guidance Journal, November, 1966.

Dollard, J. and Miller, N. E. Personality and Psychotherapy. New York: McGraw-Hill, 1950.

Dulaney, D. E. "Hypotheses and Habits in Verbal 'Operant Conditioning'". Journal of Abnormal Social Psychology, 1961, 63, 251-263.

Erickson, C. W. (Ed.), Behavior and Awareness: A Symposium of Research and Interpretation. Durham, N. D., Duke University Press, 1962.

Eysenck, H. D. (Ed.) Behavior Therapy and the Neuroses. New York: Pergamon Press, 1960.

Farber, L. E. "The Things People Say to Themselves". American Psychologist, 1963, 18, 185-197.

Fey, W. F. "Acceptance by Others and Its Relation to Acceptance of Self and Others: A Re-evaluation". Journal of Abnormal Social Psychology , 1955, 50, 274-276.

French, J. R. P. and Snyder, R. "Leadership in Interpersonal Power". In D. Cartwright (Ed.), Studies in Social Power. Ann Arbor: University of Michigan Press, 1959.

Freud, S. "Selected Papers on Hysteria and Other Psychoneuroses". (Translated by A. A. Brill), New York, Journal of Nervous and Mental Diseases. Publ. Co., 1912.

_____, "The Dynamics of the Transference". In Collected Papers of Sigmund Freud, Vol. 2, London,Hogarth Press, 1959.

Fromm-Reichmann, Freida. "Note on the Personal and Professional Requirements of a Psychotherapist", Psychiatry, 1949, 12, 361-378.

_____. "Some Aspects of Psychoanalytic Psychotherapy with Schizophrenics". In E. Brody and F. D. Redlick (Eds.), Psychotherapy With Schizophrenics. New York: International Universities Press, 1952.

_____. Principle of Intensive Psychotherapy. Chicago: University of Chicago Press, 1958.

Hoehn-Saric, R., Frank, J. D., Imber, S. D., Nash, D. H., Stone, A. R., and Battle, Carolyn C. "Systematic Preparation of Patients for Psychotherapy. I. Effects on Therapy Behavior and Outcome". J. Psychiat. Res., 1963, Z, 267-281.

Kanfer, F. H. and Marston, A. R. "Conditioning of Self-Reinforcement Responses: An Analogue to Self-Confidence Training". Psychol. Rep., 1963, 13, 63-70. (a)

_____, and _____. "Determinants of Self-Reinforcement in Human Learning". J. Eper. Psychol., 1963, 66, 245-254. (b)

Krasner, L. "The Therapist as a Social Reinforcement Machine". In H. H. Strupp and L. Luborsky (Eds.), Research in Psychotherapy. Vol. 2, Washington, D. C.: American Psychological Assoc., 1962.

Marks, I. M. and Grelder, M. G. "Deconditioning (Desensitization) in Phobic Disorders: Indications and Limitations". Paper in Symposium on higher nervous activity, IV World Psychiatry Congress, Madrid, Spain, September, 1966.

Marston, A. R. "Imitation, Self-Reinforcement, and Reinforcement of Another Person". Journal Pers. Social Psychology, 1965, 2, 225-261. (a)

_____. "Self-Reinforcement Research: Analogue to Psychotherapy". Unpublished manuscript, University of Wisconsin, 1965. (b)

May, R. "Contribution of Existential Psychotherapy". In: R. May, E. Angle and H. Ellenburger, (Eds.), Existence. New York: Basic Books, 1958.

Melloh, R. A. "Accurate Empathy and Counselor Effectiveness". Unpublished doctoral dissertation, University of Florida, 1964.

Mowrer, O. H. "A Stimulus-Response Analysis of Anxiety and Its Role as a Reinforcing Agent". Psychol. Review, 1939, 46, 553-565.

Rank, O. In Ruth L. Munroe, Schools of Psychoanalytic Thought. New York: Dryden Press, 1955, 590-592.

Raush, H. L. and Bordin, E. S. "Warmth in Personality Development and in Psychotherapy". Psychiatry, 1957, 20, 351-363.

Rogers, C. R. "The Necessary and Sufficient Conditions of Therapeutic Personality Change". J. Consult. Psychol., 1957, 21, 95-103. (a)

_____. "Training Individuals to Engage in the Therapeutic Process". In C. R. Strother (Ed.), Psychology and Mental Health. Washington, D. C.: Amer. Psychol. Association, 1957. (b)

_____, Gendlin, E. T., Kiesler, D., and Truax, C. B. "The Therapeutic Relationship and Its Impact: A Study of Psychotherapy with Schizophrenics". Madison: University of Wisconsin Press, 1967.

Schachter, S., Ellerton, T., and McBride, D. "Deviation, Rejection and Communication". Journal of Abnormal Social Psychology, 1951, 46, 190-207.

Shapiro, J. G. "Relationships Between Expert and Neophyte Ratings of Genuineness, Empathy and Warmth." Unpublished manuscript, Arkansas Rehabilitation Research and Training Center, University of Arkansas, 1967.

Shoben, E. J. "A Learning Theory Interpretation of Psychotherapy." Harvard Educ. Review, 1948, 18, 129-145.

_____. "Psychotherapy as a Problem in Learning Theory". Psychol. Bull., 1949, 46, 366-392.

_____. "Some Observations on Psychotherapy and the Learning Process". In O. H. Mower (Ed.), Psychotherapy: Theory and Research. New York: Ronald Press, 1953.

Strupp, H. H. "Psychotherapists in Action". New York: Grune and Stratton, 1960. (a)

_____. "Nature of Psychotherapists' Contribution to the Treatment Process". Arch. Gen. Psychiat., 1960, 3, 219-231. (b)

Truax, C. B. "A Scale for the Measurement of Accurate Empathy". Psychiatric Institute Bull., Wisconsin Psychiatric Institute, University of Wisconsin, 1961, 1, 12.

_____. "A Tentative Scale for the Measurement of Therapist Genuineness of Self-Congruence." Discussion Papers, Wisconsin Psychiatric Institute, University of Wisconsin, 1962, 35, (a)

_____. "A Tentative Scale for the Measurement of Unconditional Positive Regard". Psychiatric Institute Bull., Wisconsin Psychiatric Institute, University of Wisconsin, 1962, 2, 1. (b)

_____. "Effective Ingredients in Psychotherapy: An Approach to Unraveling the Patient-Therapist Interaction". J. Counsel. Psychol., 1963, 10, 3, 256-263.

_____. "Some Implications of Behavior Therapy for Psychotherapy". Journal of Counseling Psychology, 1966, 13, 160-170. (a)

_____. "The Training of Nonprofessional Personnel in Therapeutic Interpersonal Relationships". Symposium paper presented at American Public Health Association, San Francisco, November 5, 1966. (b)

_____. "Some Central Interpersonal Skills That Change Behavior". Speech presented at symposium entitled Effective Interpersonal Relationships That Produce Behavior Change. Sponsored by the Arkansas Rehabilitation Research and Training Center of the University of Arkansas and the Arkansas Rehabilitation Service, Hot Springs, Arkansas, April 19-21, 1967.

_____. "Therapist Reinforcement of Patient Self-Exploration and Therapeutic Outcome in Group Psychotherapy". Unpublished manuscript, Arkansas Rehabilitation Research and Training Center, University of Arkansas, 1967. (b)

_____, and Carkhuff, R. R. "Personality Change in Hospitalized Mental Patients During Group Psychotherapy as a Function of Alternate Sessions and Vicarious Therapy Pre-Training". J. Clin. Psychol., 1965, 21, 225-228. (a)

_____, and _____. "The Experiemental Manipulation of Therapeutic Conditions". J. Consult. Psychol., 1965, 29, 119-124. (b)

_____, and _____. "Client and Therapist Transparency in the Psychotherapeutic Encounter". J. Counsel. Psychol., 1965, 12, 3-9. (c)

_____, and _____. "Toward Effective Counseling and Psychotherapy: Training and Practice". Chicago, Aldine, 1967.

_____, _____, and Douds, J. "Toward an Integration of the Didactic and Experiential Approaches to Training in Counseling and Psychotherpy". J. Counsel. Psychol., 1964, 11, 240-247.

_____, Silber, L. D. and Wargo, D. G. "Personality Change and Achievement in Therapeutic Training". Unpublished manuscript, Arkansas Rehabilitation Research and Training Center, University of Arkansas, 1966.

_____, Tunnell, B. T., Jr. and Glenn, A. W. "Accurate Empathy, Nonpossessive Warmth, Genuineness and Patient Outcome in Silent and Verbal Outpatients". Unpublished manuscript, Arkansas Rehabilitation Research and Training Center, University of Arkansas, 1966. (a)

_____, _____, and _____. "Accurate Empathy, Nonpossessive Warmth and Genuineness of the Therapist and Patient Outcome in Most and Least Adjusted Patients". Unpublished manuscript, Arkansas Rehabilitation Research and Training Center, University of Arkansas, 1966. (b)

_____, and Wargo, D. G. "Antecedents to Outcome in Group Psychotherapy with Juvenile Delinquents: Effects of Therapeutic Conditions, Alternate Sessions, Vicarious Therapy Pretraining and Patient Self-Exploration". Unpublished manuscript, University of Arkansas, 1966. (a)

_____, and _____. "Antecedents to Outcome in Group Psychotherapy with Hospitalized Mental Patients: Effects of Therapeutic Conditions, Alternate Sessions, Vicarious Therapy Pretraining, and Patient Self-Exploration". Unpublished manuscript, University of Arkansas, 1966. (b)

_____, _____, and Carkhuff, R. R. "Antecedents to Outcome in Group Psychotherapy with Outpatients: Effects of Therapeutic Conditions, Alternate Sessions, Vicarious Therapy Pretraining and Patient Self-Exploration". Unpublished manuscript, Arkansas Rehabilitation Research and Training Center, University of Arkansas, 1966.

_____, _____, Frank, J. D., Imber, S. D., Battle, Carolyn C., Hoehn-Saric, R., Nash, E. H., and Stone, A. R. "Therapist Empathy, Genuineness and Warmth and Patient Therapeutic Outcome". J. Consult. Psychol., 1966, 30, 395-401.

Van Zelst, R. H. "Worker Popularity and Job Satisfaction". Personnel Psychology, 1951, 4, 405-412.

Vernallis, F. F. and Reinert, R. E. "An Evaluation of a Goal-Directed Group Psychotherapy with Hospitalized Patients". Group Psychotherapy, 1961, 14, 5-12.

Whitehorn, J. C. "Human Factors in Psychiatry". Bull. of N. Y. Acad. of Med., 1964, 40, 451-466.

_____, and Betz, Barbara J. "A Study of Psychotherapeutic Relationships Between Physicians and Schizophrenic Patients". Amer. J. Psychiat., 1954, 3, 321-331.

Winthrop, H. "Relation Between Appeal Value and Highbrow Status on Some Radio and Television Programs". Psychol. Reports, 1958, 4, 53-54.

Wolpe, J. and Lazarus, R. Behavior Therapy Techniques: A Guide to the Treatment of Neuroses. London: Pergamon, 1966.

Zimbardo, P. G. "Involvement and Communication Discrepancy as Determinants of Opinion Conformity". J. Abnorm. Soc. Psychol., 1960, 60, 86-94.